

General

Guideline Title

Clinical practice guideline for the management of borderline personality disorder.

Bibliographic Source(s)

National Health and Medical Research Council. Clinical practice guideline for the management of borderline personality disorder. Melbourne (Australia): National Health and Medical Research Council; 2012. 166 p. [278 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Definitions for the types of recommendations (EBT, CBT, PP) and grades for evidence-based recommendations (A–D) are provided at the end of the "Major Recommendations" field.

Identifying and Assessing Borderline Personality Disorder (BPD)

1. Health professionals should consider assessment for BPD (or referral for psychiatric assessment) for a person with any of the following:
 - Frequent suicidal or self-harming behaviour
 - Marked emotional instability
 - Multiple co-occurring psychiatric conditions
 - Non-response to established treatments for current psychiatric symptoms
 - A high level of functional impairment

(PP)

2. Once the diagnosis is established, it should be disclosed and explained to the person, emphasising that effective treatment is available. (PP)
3. If the person agrees, the diagnosis should be explained to the person's family, partner or carers at a time that both the clinician and the person think appropriate. (PP)
4. Health professionals should consider an assessment for BPD in people aged 12–18 years with any of the following:
 - Frequent suicidal or self-harming behaviour
 - Marked emotional instability
 - Multiple co-occurring psychiatric conditions

- Non-response to established treatments for current psychiatric symptoms
- A high level of functional impairment

(CBR)

5. After appropriate assessment, health professionals should make the diagnosis of BPD in a person aged 12–18 years who meets the diagnostic criteria. The diagnostic criteria for BPD should not generally be applied to prepubescent children. (CBR)
6. A thorough clinical interview should be used to diagnose BPD in young people. This can be assisted by the use of a validated semi-structured instrument. (CBR)
7. Validated BPD screening tools can be used with young people attending mental health services to identify individuals in need of further diagnostic assessment for BPD. (CBR)

Managing BPD

8. People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, and conducted by one or more adequately trained and supervised health professionals. (EBR; B) (National Collaborating Centre for Mental Health [NCCMN], 2009; Tyrer et al., 2003; Weinberg et al., 2006; Blum et al., 2008; Chanen et al., 2008; Clarkin et al., 2004; Davidson et al., 2006; Giesen-Bloo et al., 2006; Munroe-Blum & Marziali, 1995; Bateman & Fonagy, 1999; Koons et al., 2001; Linehan et al., 1991; Linehan et al., 2006; Turner, 2000; van den Bosch et al., 2002; Carter G. Hunter Dialectical Behaviour Therapy Project, 2008; Barnicot et al., 2011; Carter et al., 2010; Harned et al., 2008; McMain et al., 2009; Soler et al., 2009; Ball et al., 2011; Rowe et al., 2008; Davidson et al., 2010; Bateman & Fonagy, 2008; Bateman & Fonagy, 2009; Bos et al., 2010; Schuppert et al., 2009; Bellino, Rinaldi, & Bogetto, 2010; Bellino et al., 2006; Doering et al., 2010; Morey, Lowmaster, & Hopwood, 2010; Gregory, DeLucia-Deranja, & Mogle, 2010; Gregory et al., 2009; Kramer et al., 2011; Zanarini & Frankenburg, 2008; Cottraux et al., 2009; Farrell, Shaw, & Webber, 2009; Harned et al., 2010)
 9. When planning structured psychological therapies for BPD, the therapist should adapt the frequency of sessions to the person's needs and circumstances, and should generally consider providing at least one session per week. (CBR)
 10. Health professionals should inform people with BPD about the range of BPD-specific structured psychological therapies that are available and, if more than one suitable option is available, offer the person a choice. (CBR)
 11. Medicines should not be used as primary therapy for BPD, because they have only modest and inconsistent effects, and do not change the nature and course of the disorder. (EBR; B) (NCCMN, 2009; Bellino et al., 2006; Zanarini & Frankenburg, 2008; de la Fuente & Lotstra, 1994; Frankenburg & Zanarini, 2002; Hollander et al., 2001; Hollander et al., 2003; Loew et al., 2006; Nickel et al., 2004; Nickel et al., 2005; Tritt et al., 2005; Rinne et al., 2002; Simpson et al., 2004; Bellino et al., 2007; Soloff et al., 1989; Soloff et al., 1993; Bogenschutz & George Nurnberg, 2004; Eli Lilly, 2009; Zanarini & Frankenburg, 2001; Schulz et al., 2008; Soler et al., 2005; Nickel et al., 2006; Pascual et al., 2008; Leone, 1982; Hallahan et al., 2007; Zanarini & Frankenburg, 2003; Bellino, Paradiso, & Bogetto, 2008; Duggan et al., 2008; Ingenhoven et al., 2010; Lieb et al., 2010; Mercer, Douglass, & Links, 2009; Stoffers et al., 2010; Varghese et al., 2010; Leiberich et al., 2008; Loew & Nickel, 2008; Shaffi & Shahveisi, 2010; Ziegenhorn et al., 2009)
 12. The time-limited use of medicines can be considered as an adjunct to psychological therapy, to manage specific symptoms. (CBR)
 13. Caution should be used if prescribing medicines that may be lethal in overdose, because of high suicide risk with prescribed medicines among people with BPD. (PP)
 14. Caution should be used if prescribing medicines associated with substance dependence. (PP)
 15. Before starting time-limited pharmacotherapy for people with BPD:
 - Ensure that a medicine is not used in place of other, more appropriate interventions
 - Take account of the psychological role of prescribing (both for the individual and for the prescriber) and the impact that prescribing decisions may have on the therapeutic relationship and the overall BPD management plan, including long-term treatment strategies
 - Use a single medicine and avoid polypharmacy, if possible
 - Ensure that there is consensus among prescribers about the medicine used, and collaboration with other health professionals involved in the person's care, and that the main prescriber is identified
 - Establish likely risks of prescribing, including interactions with alcohol and other substances
- (PP)
16. The use of medicines can be considered in acute crisis situations where psychological approaches are not sufficient. (PP)
 17. If medicines have been prescribed to manage a crisis, they should be withdrawn once the crisis is resolved. (PP)
 18. When reduction in self-harm is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. (EBR; B) (Koons et al., 2001; Linehan et al., 1991; Turner, 2000; Carter et al., 2010; Bohus et al., 2004)
 19. When reduction in anger, anxiety or depression is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program. (EBR; B) (Koons et al., 2001; Linehan et al., 1991; Turner, 2000; Carter et al., 2010; Bohus et al., 2004)
 20. Pharmacotherapy should not be routinely added to psychological interventions in the treatment of BPD. (EBR; D) (Bellino, Rinaldi, &

Bogetto, 2010; Bellino et al., 2006; Simpson et al., 2004; Soler et al., 2005)

21. In addition to one-to-one psychological therapies, consider offering psychoeducation, family therapy and/or group sessions, as appropriate to the person's needs. (CBR)
22. People aged 14–18 years with BPD or clinically significant features of BPD should be offered time-limited structured psychological therapies that are specifically designed for BPD. (EBR; B) (Schuppert et al., 2009; Chanen et al., 2009)
23. Adolescents with BPD should be referred to structured psychological therapies that are specifically designed for this age group. Where unavailable they should be referred to youth mental health services. (PP)
24. When planning treatment for people under 18 years with BPD or clinically significant features of BPD, consider the person's developmental stage and living circumstances, and involve their family in care as appropriate. (PP)
25. For adolescents younger than 14 years with features of BPD, offer clinical psychological support and monitoring, involving their families. (PP)
26. For people with BPD who have a co-occurring mental illness (e.g., a substance use disorder, mood disorder or eating disorder), both conditions should be managed concurrently. (CBR)
27. Interventions for BPD and co-occurring mental illness should be integrated, where possible. If possible, the same therapist or treatment team should provide treatment for both conditions. Where this is not possible, the health service or therapist providing treatment for the co-occurring condition should collaborate with the person's main clinician who is responsible for managing their BPD. (CBR)
28. If a person's substance use is severe, life-threatening or interfering with BPD therapy, health professionals should actively work to engage the person in effective BPD treatment, but give priority in the first instance to the stabilisation of their substance use disorder to allow effective BPD treatment. Treatment should focus on managing the substance use disorder before effective BPD treatment can continue. (CBR)
29. Medical symptoms in people with BPD should be thoroughly assessed and managed effectively by a general practitioner (GP) or appropriate specialist. (CBR)
30. GPs should provide advice and follow-up (e.g., reminders) to encourage people with BPD to participate in screening and preventive health measures, such as cervical cancer screening for women. (PP)

*Standardised, manual-based therapy using the method developed by its originators.

Organising Healthcare Services to Meet the Needs of People with BPD

31. The majority of a person's treatment for BPD should be provided by community-based mental health services (public and private). (CBR)
32. BPD treatments should be offered through a range of services, as appropriate to the individual's current clinical presentation, course of illness, needs and (if applicable) preferences. (CBR)
33. Acute inpatient admission to provide structured crisis intervention could be considered for the treatment of people who are suicidal or have significant co-occurring mental health conditions. (EBR; C) (Berrino et al., 2011)
34. Inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. Where used, inpatient care should be:
 - Brief (except for specialised structured residential services that provide intensive interventions)
 - Directed towards specific, pre-identified goals(CBR)
35. Long-term inpatient care for people with BPD should generally be avoided, except in the context of specialised BPD services. (CBR)
36. When considering inpatient care for a person with BPD, health professionals should involve the person (and family or carers, if possible) in the decision, and ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm that may result from admission, and agree on the length and purpose of the admission in advance. (PP)
37. Health professionals should consider referring people with severe and/or enduring BPD to a suitable specialised BPD service (where available) for assessment and ongoing care, if appropriate. (CBR)
38. Health professionals at all levels of the healthcare system and within each type of service setting should:
 - Acknowledge that BPD treatment is a legitimate use of healthcare services
 - Be able to recognise BPD presentations
 - Be aware of general principles of care for people with BPD and specific effective BPD treatments
 - Provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for co-occurring mental illness) according to their level of training and skill
 - Refer the person to a specialised BPD service or other services as indicated
 - Undertake continuing professional development to maintain and enhance their skills(CBR)

39. Clinicians treating people with BPD should follow a stepped-care approach in which an individual's usual care is based on the least intensive treatment (such as general practice care and regular contact with a community mental health service), and referral to more intensive treatment (such as crisis intervention, a specialised BPD service, or specialised BPD programs) is provided when indicated. (CBR)
40. Health professionals within each type of service should set up links with other services to facilitate referral and collaboration. (CBR)
41. Managers and health system planners should configure services to ensure that people can access more intensive treatment options, such as a specialised BPD service, when needed. (CBR)
42. If more than one service is involved in an individual's care, services should agree on one provider as the person's main contact (main clinician), who is responsible for coordinating care across services. (CBR)
43. All health professionals treating people with BPD should make sure they know who the person's main clinician is. (CBR)
44. Health system planners should ensure that people have access to healthcare services appropriate to their needs within their local area or as close as possible. (CBR)
45. Where more than one treatment option or service setting is suitable for an individual's clinical needs, health professionals should explain the options and support the person to choose. (CBR)
46. Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive training in BPD management. (CBR)
47. For group practices or services with several health professionals, training should involve all staff within a service, using a group learning approach. (CBR)
48. Service managers should ensure that caseloads for clinicians who treat people with BPD are appropriate and realistic according to:
 - Their experience
 - The needs of individuals according to phase of treatment
 - The requirements of the specific treatments provided
 - The number of complex cases
 (CBR)
49. Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive adequate supervision according to their level of experience and BPD caseload (taking into account case complexity). (CBR)
50. Those responsible for planning or managing services that provide care for people with BPD should ensure that health professionals receive appropriate support, including:
 - Participation in a structured peer support program
 - Access to secondary consultation provided by an expert in BPD care or specialised BPD service
 (CBR)

Supporting Families and Carers

51. Health professionals should refer families, partners and carers of people with BPD to support services and/or psychoeducation programs on BPD, where available. (CBR)
52. Health professionals should provide families, partners and carers of people with BPD with information about BPD or direct them to sources of reliable information. (CBR)
53. Health professionals should include families, partners and carers of people with BPD when developing crisis plans, if possible and with the person's consent. (CBR)
54. Health professionals should provide families, partners and carers of people with BPD with information about dealing with suicide attempts or self-harm behaviour. (CBR)
55. Health professionals should advise families, partners and carers of people with BPD about helpful ways of interacting with the person who has BPD, including:
 - Showing empathy and a non-judgemental attitude
 - Encouraging the person to be independent by allowing and supporting them to make their own decisions, but intervening for their safety when necessary
 - Listening to the person with BPD when they express their problems and worries
 (CBR)
56. When discussing childhood trauma, including sexual abuse, with the family of a person with BPD, health professionals should manage these discussions in a manner that minimises guilt, stigma and blame. Such discussions should occur with the consent of the person with BPD, (taking into account child protection legislation if the person is a minor). (CBR)
57. Health professionals caring for parents with BPD should consider the needs of children and arrange assessment of their mental health and welfare needs if necessary. (PP)
58. Health professionals assessing a person with BPD (particularly during a crisis) should determine whether the person has dependent children

and ensure that they are properly cared for (e.g., refer to a social worker). (PP)

59. Health professionals can support families, partners and carers by referring or directing them to:

- General family counselling and psychoeducation with a focus on BPD
- Structured family programs specific to BPD
- Peer support programs such as carer-led programs that educate families/carers on BPD
- Respite services

(CBR)

60. If a mother with BPD requires hospital admission, separation from her infant should be avoided if possible. (PP)

61. Health professionals involved in the assessment of parenting capacity should advise authorities that a parent's BPD alone is not sufficient reason for removing a child from the parent's care. (PP)

62. People with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships. (PP)

63. Where children are carers of an adult with BPD, specific support should be provided, including:

- Education about the parent's mental illness
- Strategies for management of adult's emotional and psychological states
- Strategies for helping them with peer relationships and social functioning
- Psychological and emotional support
- Referral to services for young people who are carers
- Respite services

(PP)

Definitions:

Types of Recommendations

Abbreviation	Type of Recommendation	Description
EBR	Evidence-based recommendation	Recommendations formulated by the guideline development committee/group based on high-quality evidence and graded according to a National Health and Medical Research Council (NHMRC)-approved method.
CBR	Consensus-based recommendation	Recommendations formulated by the guideline development committee/group, using a consensus-reaching process, in the absence of high-quality evidence (where a systematic review of the evidence was conducted as part of the guideline search strategy).
PP	Practice point	Point of guidance included in the guideline used to support evidence-based recommendations, where the subject matter is outside of the scope of search strategy, and which were formulated based on expert opinion using a consensus process.

Grades for Evidence-based Recommendations

Grade	Description
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Borderline personality disorder (BPD)

Guideline Category

Counseling

Diagnosis

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Emergency Medicine

Family Practice

Internal Medicine

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Occupational Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

- To improve the diagnosis of borderline personality disorder (BPD)
- To improve the care of people with BPD, and to relieve their distress and suffering
- To provide a summary of current evidence for the effectiveness and efficacy of treatments for BPD

- To guide health professionals in the care of people with BPD or features of BPD within Australian healthcare services, by providing evidence-based recommendations and, where there is insufficient evidence, providing recommendations based on consensus
- To help health professionals support the families and carers of people with BPD
- To provide guidance on the organisation of healthcare services

Target Population

- Adolescents (aged 12–18 years) and adults (aged over 18 years) with a diagnosis of borderline personality disorder (BPD)
- Adolescents and adults who show features of BPD
- Individuals with BPD who have a co-occurring mental health condition

Interventions and Practices Considered

1. Identifying and assessing borderline personality disorder (BPD)
 - Assessment based on symptoms
 - Explanation of diagnosis to patient and family
 - Assessment in young people
 - Use of validated semi-structured diagnostic and assessment instruments for young people
2. Managing BPD
 - Structured psychological therapies for BPD
 - Pharmacotherapy for BPD (time-limited)
 - Targeting specific outcomes
 - Delivery modes for BPD treatments
 - BPD treatment for adolescents
 - Managing co-occurring health conditions in people with BPD, including co-occurring mental conditions
 - Managing complex and severe BPD
3. Organising healthcare services to meet the needs of people with BPD
 - BPD treatment delivered by different types of healthcare services (public and private)
 - Role of acute inpatient care
 - Role of long-term inpatient care
 - Role of specialised BPD services
 - Roles of various health professionals in BPD care
 - Coordinating care for people with BPD
 - Supporting health professionals who care for people with BPD
4. Supporting families, partners and carers
 - Interventions directed at families, partners and carers to support the care of a person with BPD
 - Interventions to meet families', partners' and carers' needs

Major Outcomes Considered

- Anger, hostility, irritability
- Suicidal/self-harm behaviour
- Anxiety
- Depression
- General functioning
- Social/interpersonal functioning
- Borderline personality disorder symptoms
- General psychopathology
- Hospitalisation
- Suicidal ideation
- Weight
- Quality of life

- Adverse effects of therapy

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Inclusion and Exclusion Criteria

For inclusion in the review, studies needed to be concerned with the treatment of primary or secondary presentations of borderline personality disorder (BPD). These studies had to be of adequate quality, being no lower than Level III-3 in the National Health and Medical Research Council (NHMRC) Evidence Hierarchy (see the "Rating Scheme for the Strength of the Evidence" field). Level III studies were assessed and considered for eligibility. Additional inclusion criteria outlined that the studies had to be published in English, have human subjects, and be published between January 2008 and April 2011 (for updated clinical questions). For new clinical questions, the inclusion criteria were the same, except that the search dates were January 2001 to April 2011. The committee developed inclusion and exclusion criteria at their initial meeting in February 2011. See the table below.

Table. Inclusion and Exclusion Criteria

Inclusion	Exclusion
Published in English or with English translation	Not meeting level of evidence
2001–2011 for new questions 2008–2011 for updated questions	Out of date range (including newer articles published after the initial search dates)
Level I to III-3: search highest level and if less than 3 papers then include next level	Level 4 studies Non-systematic reviews
Primarily BPD data or specific analysis with BPD	Not primarily BPD

Searching the Literature

Selection of High Quality Source Documents to Use for Adaptation

In accord with the ADAPTE process, a number of international guideline databases were used to search for guidelines related to the treatment and management of borderline personality disorder. This search revealed two guidelines, one developed by the American Psychiatric Association (APA) in 2001, and another more recent guideline developed in the United Kingdom by the National Institute for Health and Care Excellence (NICE).

The APA guideline on BPD was not developed using a systematic search of the literature, and did therefore not meet the *Procedures and requirements for meeting the 2011 the National Health and Medical Research Council (NHMRC) standard for clinical practice guidelines*, nor was it suitable for adaption. The NICE guideline systematically reviewed the literature and performed favourably when assessed with the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument. Therefore, the guideline funder agreed to adapt the NICE guideline.

The NHMRC was granted permission from the lead authors of the NICE guideline to adapt the UK guideline to Australian circumstances.

Development of a Search Strategy and Search of the Literature

This guideline is an adaptation of the UK NICE Guideline. Where the committee agreed to update the clinical questions included in the NICE guideline, all papers retrieved by NICE were used as the evidence base from 2001 to 2008. The systematic search was used to update the body of evidence for the NICE questions from 2008 to 2011. The term "updated search" is used throughout this guideline to describe the process of the systematic search of the literature used to update the body of evidence for the NICE questions. For the 5 new clinical questions not previously

included in the NICE guideline, a new strategy from 2001 was undertaken.

The updated searches for the NICE questions were based upon new search strings developed using a combination of:

- The searches undertaken in the NICE guideline
- The aims and scope of the NHMRC guideline
- The clinical questions and inclusion and exclusion criteria developed by the Guideline Development Committee in February 2011, and those of the NICE guideline

Groups of key terms were searched then systematically combined to explore the various sets of clinical questions across all databases. An overall search was undertaken, followed by specific searches for each question. Terms used were a combination of Medical Subject Heading (MeSH) (and other database thesaurus) headings, keyword terms and words in the text and titles.

Appendix D (see the "Availability of Companion Documents" field for all appendices) contains the string search for each question. Additional searches of the literature were conducted to extract relevant studies related to Aboriginal and Torres Strait Islander peoples, as well as the cost-effectiveness of BPD treatments.

The search strategy was applied to four electronic databases during April–June 2011. The databases searched were: MEDLINE, PsycINFO, EMBASE and the Cochrane Database of Systematic Reviews. Initially, the search period was 2008–2011, as indicated in the table below. However, for new questions developed by the NHMRC committee, the search period was 2001–2011.

Table. Database Search

Database	Accessed via	Search Period*	Number of Citations Found (Duplicates Removed)
MEDLINE	Ovid	2008–2011	559
PsycINFO	Ovid	2008–2011	448
EMBASE	EMBASE	2008–2011	5430
Cochrane	Wiley	2008–2011	208

*Search period for new questions (Q3, Q4, Q10, Q11 and Q14) was 2001–2011.

Number of Source Documents

First Screen

- Number of citations screened after duplicated and irrelevant records removed: 264
- Number of citations excluded at first screen: 126

Second Screen

- Number of studies assessed for quality: 138
- Number of studies excluded at second screen: 89

Final Review

- Number of studies included in final review: 49

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

National Health and Medical Research Council (NHMRC) Evidence Hierarchy: Designations of "Levels of Evidence" According to Type of Research Question

Level	Intervention	Diagnostic Accuracy	Prognosis	Aetiology	Screening Intervention
I	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies
II	A randomised controlled trial	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among consecutive persons with a defined clinical presentation	A prospective cohort study	A prospective cohort study	A randomised controlled trial
III-1	A pseudorandomised controlled trial (i.e., alternate allocation or some other method)	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among non-consecutive persons with a defined clinical presentation	All or none	All or none	A pseudorandomised controlled trial (i.e., alternate allocation or some other method)
III-2	A comparative study with concurrent controls: <ul style="list-style-type: none"> • Non-randomised, experimental trial • Cohort study • Case-control study • Interrupted time series with a control group 	A comparison with reference standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst persons in a single arm of a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: <ul style="list-style-type: none"> • Non-randomised, experimental trial • Cohort study • Case-control study
III-3	A comparative study without concurrent controls: <ul style="list-style-type: none"> • Historical control study • Two or more single arm study • Interrupted time series without a parallel control group 	Diagnostic case-control study	A retrospective cohort study	A case-control study	A comparative study without concurrent controls: <ul style="list-style-type: none"> • Historical control study • Two or more single arm study
IV	Case series with either post-test or pre-test/post-test outcomes	Study of diagnostic yield (no reference standard)	Case series, or cohort study of persons at different stages of disease	A cross-sectional study or case series	Case series

Methods Used to Analyze the Evidence

Meta-Analysis

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Summary of the Relevant Data

A final list of included studies is contained in Appendix E of the original guideline document (see the "Availability of Companion Document" field for all appendices). Based on the extraction forms and quality checklists, evidence tables and summary tables were created for each clinical question (see Appendix H in the original guideline document). These tables were presented to the BPD Guideline Development Committee.

Meta-analysis for Clinical Questions 6, 7, 8 and 9

At the Committee meeting in August 2011, the committee discussed whether a meta-analysis of the literature from 1990 to 2011 would contribute to the body of evidence on the effectiveness of psychological and pharmacological treatment options for borderline personality disorder (BPD) (clinical questions 6, 7, 8 and 9). Following independent methodological advice, a meta-analysis was conducted for these questions which drew from the studies identified in the National Institute for Health and Care Excellence (NICE) guideline for these clinical questions, as well as those identified in the updated search.

Meta-analysis Search Strategy

Data for the meta-analysis was obtained from two sources:

- i. The updated search results
- ii. Articles identified in the NICE guideline included in the relevant questions.

Inclusion and Exclusion Criteria of the Meta-analysis

Studies were included in the systematic review if they met the following criteria:

- i. Diagnosis of BPD in at least 70% of the sample
- ii. Sample contained primarily adults (18+ years)
- iii. Reported outcomes relevant to outcome categories of interest to this review (anger, hostility, irritability, suicidal/self-harm behaviour, anxiety, depression, general functioning, social/interpersonal functioning, BPD symptoms, general psychopathology, hospitalisation, suicidal ideation, weight) (see Appendix G of the original guideline document for included and excluded scales)
- iv. There was enough information contained in the published article to be able to calculate a study effect size.

See Appendix F in the original guideline document for a list of the studies included in the meta-analysis.

Coding Procedures for the Meta-analysis

From each eligible study, information was extracted for all measures relevant to the outcome categories of interest in this review. Information extracted included study identifiers (citation, name/type of treatment, name/type of control, length of treatment, time of follow-up measurement), basic demographics (age, gender, percentage with diagnosed BPD), outcome identifiers (name of the scale, outcome variable the scale measured), and information necessary to calculate study effect size (depending on the availability of the data: sample size, means, standard deviation/standard error, or standardised mean difference and 95% confidence interval or sample size and an exact p value, for both the treatment and control groups). One reviewer entered the information into a form specifically created for this review, which was checked by a second reviewer.

Data Analysis

Analyses were completed using Comprehensive Meta-Analysis Version 2. Firstly, effect sizes (\pm 95% confidence interval [CI]) were calculated for each relevant outcome measure in the psychological and pharmacological treatment RCTs. These effect sizes were standardised mean differences (Cohen's d) comparing active treatment and control groups on each relevant outcome measure.

A positive effect size indicates that the scores were higher for the treatment than the control group, and a negative effect size indicates scores were lower in the treatment group; whether this represents a better result for the treatment group depends on the measure. For example, for the Hamilton Depression Rating Scale, a lower score in the treatment group than the control group would indicate that the treatment group fared better, with lower levels of depression; this would result in a negative effect size. For a measure of functioning (e.g. Global Assessment of Functioning), a higher score in the treatment group than the control group would represent a better outcome for the treatment group; this would result in a positive effect size.

The study effect sizes were then weighted by variance and pooled in a series of random-effects meta-analyses. Firstly, separate meta-analyses were undertaken for each outcome category of scale used in the studies. Different scales that measured a similarly operationally defined outcome

category could be pooled because standardised mean difference was used. As each study may only contribute one measurement to each analysis, the extracted information was reviewed to identify studies, which used more than one scale to measure an outcome category. Measures common to other studies were selectively included to minimise heterogeneity. Secondly, for each outcome category in the psychological treatment studies, a separate meta-analysis was completed for measurements taken immediately after treatment and at the last available follow-up after the end of treatment. Finally, subgroup analyses were completed for each specific type of treatment. Forest plots were generated for each analysis. When there was only a single study in a particular treatment type, the study effect size was graphed. Due to the number of multiple comparisons, significance was set at $\alpha = .01$ to control type 1 error.

Caution in Interpretation of the Meta-analysis

Ideally in a meta-analysis, similar studies are pooled, e.g., similar in terms of types of treatment groups, types of controls, types of participants (including recruitment source, age, gender), and types of measurement scale used, otherwise sources of heterogeneity are introduced that make it difficult to interpret observed effect sizes.

Heterogeneity within this meta-analysis has been minimised by pooling together studies with similar time-points (immediately following treatment) and similar scales. In this analysis, heterogeneity was reduced by conducting subgroup analyses of specific types of treatment within the broad classes, however this has resulted in a small number of studies in each sub-group.

There is the strong possibility of file-drawer problem, whereby other trials exist that were not recovered in the systematic search that could substantially affect the results. There were also instances where scales relevant to outcomes could not be included in the forest plots because sufficient information was not provided (e.g., it was simply stated that differences between groups on that scale were not significant). This biases the observed effect sizes away from the null.

It was not possible to test for file-drawer graphically or mathematically because there were so few studies in this meta-analysis. As only a small number of studies are included in the meta-analysis, the addition of new studies may substantially alter the observed pooled effect sizes. Therefore, the effect sizes calculated in this review should be regarded simply as a summary of data available at the time of analysis, rather than an accurate reflection of true effects. To more closely approach the true treatment effects, there would need to be more studies and more data to be gathered.

The forest plots and a summary of the meta-analysis are detailed in Appendix H in the original guideline document (see the "Availability of Companion Documents" field).

Methods Used to Formulate the Recommendations

Expert Consensus (Nominal Group Technique)

Description of Methods Used to Formulate the Recommendations

Multidisciplinary Committee

In January 2011, the National Health and Medical Research Council (NHMRC) convened a multidisciplinary committee of clinical, consumer and carer representatives with specific expertise in borderline personality disorder (BPD). Members of the BPD Guideline Development Committee (the Committee) are listed in Table 1.2 in the original guideline document. The process for the Committee's appointment is described in Appendix A.2 in the original guideline document.

The Committee's terms of reference are shown in Table 1.4 in the original guideline document.

Adaption Process

High-quality clinical guidelines for managing BPD already exist in other countries. Therefore, NHMRC developed this guideline using an established guideline methodology for adapting existing guidelines (ADAPTE), rather than developing a guideline de novo. The intent of the ADAPTE process is to reduce duplication of effort by using existing good quality and current guidelines as the foundation for developing a local guideline.

In accordance with the ADAPTE process, the Committee developed this guideline by adapting relevant clinical questions from a 2009 United Kingdom (UK) guideline produced by the National Institute for Health and Care Excellence (NICE): Borderline personality disorder: treatment and management. National clinical practice guideline number 78 (UK national BPD clinical practice guideline).

The UK national BPD clinical practice guideline was selected from existing evidence-based guidelines as the most suitable source guideline for

adaptation to the Australian healthcare system, using the Appraisal of Guidelines for Research and Evaluation instrument (AGREE). The AGREE instrument measures the extent to which potential bias has been adequately addressed and managed in the guideline development process, but does not assess the content of the guideline.

Clinical Questions

This guideline was designed to answer a series of practical questions (see Chapter 11 in the original guideline document) about how to treat people with BPD, how to support families and carers of people with BPD, and how the configuration of health services can best meet the needs of people with BPD. Special needs of Aboriginal and Torres Strait Islander people with BPD were also considered. Clinical questions appropriate for literature searching, including twenty-one clinical questions adapted from the source guideline (UK national BPD clinical practice guideline) and five new clinical questions, were formulated using the PICO structure (population, intervention/indicator, control/comparator, outcome).

The process for formulating clinical questions is described in Appendix B.1 in the original guideline document.

Assess the Body of Evidence and Formulate Recommendations

Where available, information about the health economic impact of treatment options is provided. In formulating recommendations, the committee considered the evidence including studies collected from the NICE searches, the updated searches and, where relevant, the meta-analysis.

The following table outlines the consensus process that the committee used to formulate recommendations for the guideline.

Table. Consensus Process

Stages of Consensus Process	Stage in Guideline Development
<p>Stage One – Review the Evidence During committee meetings from May to October 2011, the methodologist guided the committee through the evidence tables (summarised evidence derived from the systematic literature search) and answered any questions the committee had regarding the body of evidence. The methodologist did not participate in formulating recommendations.</p>	<p>Guideline Development Committee Meetings (May, July, August, October 2011)</p>
<p>Stage Two – Review the Evidence The committee used the National Health and Medical Research Council (HMRC) Evidence Statement Form (see Appendix I in the original guideline document) to grade the body of evidence. This form was used to review the body of evidence with regard to the volume of evidence, its consistency, the clinical impact, generalisability and applicability. These aspects were graded according to the NHMRC grading criteria.</p>	
<p>Stage Three – Open Discussion After the committee reviewed the evidence, the Chair opened discussions, ensuring that advice was provided from all committee members. The committee used the results from the NHMRC Evidence Statement Form to firstly discuss if the body of evidence could be used to make recommendations. If the committee determined that the evidence could be used to formulate recommendations, they then proceeded to make recommendations based on the summarised body of evidence (evidence-based recommendations). Where evidence was available but considered insufficient to make recommendations, expert opinion was sought from the committee (consensus-based recommendations). This process was used by the Chair to guide discussions. The committee also developed practice points for areas where recommendations were made outside of the scope of the search strategy.</p>	
<p>Stage Four – Formulate Draft Recommendations Through committee discussions, the draft recommendations were formulated and graded using the NHMRC Evidence Statement Form and the consensus process.</p>	
<p>Stage Five – First Call for Agreement In the first instance, the committee assessed the extent of agreement with the recommendation and the Chair called for a discussion on any aspects where there was disagreement.</p>	
<p>Stage Six – Second Call for Agreement After the second round of discussions the Chair then called for agreement for a second time. If consensus was gained, the committee moved to the next section of the guideline. If consensus was not gained then, depending on the issue, one of the following actions was taken:</p> <ul style="list-style-type: none"> • A sub-committee (based on the committee members area of expertise), was formed to convene out of session via teleconference. The sub-committee's drafted recommendations were then tabled for discussion at subsequent meetings. • Individual committee members with expertise in the relevant area were nominated to work with NHMRC staff to draft recommendations for the committee to consider. The draft recommendations were tabled for discussion at subsequent 	

Stages of Consensus Process	Stage in Guideline Development
<p>Stage Seven – Consultation with Absent Committee Members</p> <p>NHMRC staff and the committee Chair consulted with members that were absent from meetings, outlining the draft recommendations that were formed at those meetings.</p>	November and December 2011
<p>Stage Eight – Draft Recommendations Circulated to Committee</p> <p>The guideline manuscript, containing the draft recommendations, was circulated to the committee for review before each meeting.</p>	Out of Session Between committee meetings
<p>Stage Nine – Finalise Recommendations for Public Consultation</p> <p>At the committee meeting in December 2011, the draft recommendations were reviewed, discussed and finalised for release for public consultation. Committee members who were unable to attend this meeting submitted their preferences on the draft recommendations prior to the session. For recommendations that required further editing during this meeting, the same consensus process was applied as described in stages 5–8:</p> <ul style="list-style-type: none"> • Chair made first call for agreement • The recommendation was discussed further and refined • Chair made second call for agreement 	Guideline Development Committee Meeting December 2011
<p>Stage 10 – Revision of Recommendations after Public Consultation</p> <p>At the June 2012 Committee meeting, some consensus recommendations were revised in response to comments received during public consultation. The same consensus process was applied as described in stages 5–8.</p>	Guideline Development Committee Meeting June 2012

For each evidence-based recommendation (EBR), supporting references are listed and the grade of recommendation is indicated according to NHMRC *Levels of evidence and grades for recommendations for developers of guidelines*.

Recommendations made in the absence of quality evidence (where a systematic review of the evidence was conducted as part of the search strategy) are clearly labelled as consensus-based recommendations (CBR). Any further recommendations included in the guideline where the subject matter is outside of the scope of the search strategy are clearly labelled as practice points (PP).

Methods Used to Develop Consensus-Based Recommendations

The Committee used a modified Nominal Group Technique to develop recommendations for those clinical questions for which there was insufficient evidence to formulate EBRs.

The process involved the following steps:

1. Individual Committee members used their expert opinion to formulate potential recommendations.
2. The Chair asked each member of the Committee to express their expert opinions/ideas in a round robin process and all contributions were recorded.
3. Members discussed the ideas generated, organised the list to structure content and remove duplications, then drafted one or more recommendations.
4. Members gave their preliminary vote on the decision or recommendation.
5. Members discussed the vote outcome (including additions and further merging of overlaps, as necessary).
6. Members gave their final vote on the priority of items.

Rating Scheme for the Strength of the Recommendations

Types of Recommendations

Abbreviation	Type of Recommendation	Description
EBR	Evidence-based recommendation	Recommendations formulated by the guideline development committee/group based on high-quality evidence and graded according to a National Health and Medical Research Council (NHMRC)-approved method.

Abbreviation	Type of Recommendation	Description
CBR	Consensus-based recommendation	Recommendations formulated by the guideline development committee/group, using a consensus-reaching process, in the absence of high-quality evidence (where a systematic review of the evidence was conducted as part of the guideline search strategy).
PP	Practice point	Point of guidance included in the guideline used to support evidence-based recommendations, where the subject matter is outside of the scope of search strategy, and which were formulated based on expert opinion using a consensus process.

Grades for Evidence-based Recommendations

Grade	Description
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Cost Analysis

Summary of Evidence: Cost-effectiveness

The UK national Borderline Personality Disorder (BPD) clinical practice guideline identified seven studies that assessed the cost-effectiveness of psychological treatments and treatment programs based on psychological approaches including cognitive behavioural therapy (CBT), schema-focussed psychotherapy (SFP), transference-focussed psychotherapy (TFP), psychodynamic interpersonal therapy (The Conversational Model), mentalisation-based therapy (MBT), dialectical behaviour therapy (DBT) and therapeutic communities.

In addition, the updated systematic review identified one level II study.

Discussion: Cost-effectiveness

Evidence on the cost-effectiveness of psychological therapies in the treatment of people with BPD was limited, inconsistent and not generally applicable to the Australian healthcare system.

A 2006 systematic review of psychological therapies for BPD suggested DBT was potentially cost-effective, but the review had methodological limitations. Australian studies reported that DBT was more cost-effective than treatment as usual, and that psychodynamic interpersonal therapy (The Conversational Model) resulted in savings in healthcare costs compared with pre-therapy healthcare usage, particularly among recipients who were heavy users of healthcare services. Data from a United Kingdom (UK) clinical trial suggested that MBT with partial hospitalisation was potentially more cost-effective than treatment as usual, based on limited cost data.

A UK clinical trial including cost-effectiveness measures found that CBT was unlikely to be more cost-effective than other treatments in people with BPD. Data from a Dutch multicentre clinical trial suggest that SFP was less costly than TFP over 4 years. Studies assessing cost-effectiveness of therapeutic communities were of limited quality and application to the Australian healthcare system.

No evidence on the cost-effectiveness of pharmacological treatments for people with BPD was identified.

The Committee determined that there was insufficient evidence to formulate evidence-based recommendations on the cost-effectiveness of treatments for BPD, and elected not to make consensus-based recommendations.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Public Consultation

Public consultation was conducted from 1 April to 14 May 2012. During this period the draft guideline was available on the National Health and Medical Research Council (NHMRC) website.

Notification was posted in *The Australian* national newspaper. NHMRC also invited a range of stakeholders to make submissions.

Forty-nine submissions were received. The Committee met on 7 and 8 June 2012 to consider all responses to the public consultation submissions. The draft guideline was revised where the Committee considered necessary.

Independent Methodological Review and Independent Clinical Expert Review

The amended draft was reviewed by an independent expert in research and evidence synthesis methodology, to determine whether the Committee had properly followed NHMRC procedures and whether the final guideline met the requirements of the NHMRC 2011 standard.

The guideline and recommendations have been assessed by three reviewers independent of the guideline development process using the Appraisal of Guidelines Research and Evaluation (AGREE) II instrument.

The draft was also reviewed by three independent clinicians with expertise in borderline personality disorder (BPD) management. The independent clinical reviewers considered whether the appropriate evidence was identified and reviewed in line with the stated scope and clinical questions, whether the risks and potential harms of recommendations were properly considered, and whether any conflicts between the guideline recommendations and those of other current guidance were justified by the evidence and their rationale adequately explained.

The guideline was further amended in response to recommendations from the methodological and independent clinical expert reviewers.

The final guideline was submitted to the NHMRC Council on 4 October 2012.

NHMRC approved the guideline on 25 October 2012.

Evidence Supporting the Recommendations

References Supporting the Recommendations

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Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

When formulating the recommendations, the Committee considered both the findings and recommendations of the United Kingdom (UK) national borderline personality disorder (BPD) clinical practice guideline (*Borderline personality disorder: treatment and management. National clinical practice guideline number 78*), and the findings of a new systematic evidence review undertaken for this guideline.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of borderline personality disorder (BPD)

Potential Harms

- Before prescribing any medicine for a person with borderline personality disorder (BPD), prescribers should carefully consider potential interactions with alcohol and other substances, potential drug-to-drug interactions with other prescription and non-prescription medicines, and potential adverse effects in overdose. People with BPD are at elevated risk of attempted suicide using prescription medicines (e.g., monoamine oxidase inhibitors, tricyclic antidepressant agents, lithium).
- Some people may experience distress if they are told the diagnosis of BPD at an inappropriate time or context. The diagnosis must be explained carefully, using non-technical language. The term 'borderline' is not meaningful to people with BPD and their families and friends and, for some people, it may have associations with blame and stigma.
- The issue of whether or not to tell an adolescent that they have BPD has been controversial. Some health professionals have preferred to withhold the diagnosis, even when confident of its accuracy, due to concerns about stigma and discrimination the person may experience as a result of the BPD label.

Qualifying Statements

Qualifying Statements

This document is a general guide to appropriate practice, to be followed subject to the clinician's judgement and patient's preference in each individual case. The guideline is designed to provide information to assist decision-making and is based on the best available evidence at the time of development of this publication.

Implementation of the Guideline

Description of Implementation Strategy

Dissemination and Implementation of the Guideline

Electronic versions of the guideline and summary documents are available on the National Health and Medical Research Council (NHMRC) website and the NHMRC clinical practice guidelines portal (www.clinicalguidelines.gov.au)

A mail-out to key stakeholders announcing the release of the guideline and summary documents was undertaken and included details of how to access an electronic copy or order a hardcopy version. The release of the guideline was also communicated to stakeholders through media releases, NHMRC newsletters and industry websites.

A quick reference guide version of this guideline has been created to support implementation.

Research shows that guideline implementation strategies should be multifaceted. Appropriate strategies for dissemination and implementation of this guideline may include attendance at conferences of health professionals, development and distribution of educational materials, and engaging opinion leaders to help promote key messages. Implementation at the local level should involve examining the barriers and enablers to best practice, and tailoring strategies accordingly to promote uptake.

Implementation Tools

Chart Documentation/Checklists/Forms

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Health and Medical Research Council. Clinical practice guideline for the management of borderline personality disorder. Melbourne (Australia): National Health and Medical Research Council; 2012. 166 p. [278 references]

Adaptation

The National Health and Medical Research Council used a structured guideline adaptation methodology known as ADAPTE to translate the following United Kingdom's National Institute for Health and Clinical Excellence (NICE) Guideline on the Treatment and Management of Borderline Personality Disorder, for Australian health-care settings:

- National Collaborating Centre for Mental Health. Borderline personality disorder: treatment and management. National clinical practice guideline number 78. Leicester: The British Psychological Society and The Royal College of Psychiatrists; 2009.

Date Released

2012

Guideline Developer(s)

National Health and Medical Research Council - National Government Agency [Non-U.S.]

Source(s) of Funding

The development and publication of this guideline by the National Health and Medical Research Council (NHMRC) was funded by the Australian Government Department of Health and Ageing. The involvement of the Department of Health and Ageing was limited to determining the scope of the guideline, and it had no involvement in the Committee's process of assessing evidence and formulating recommendations.

Guideline Committee

BPD Guideline Development Committee

Composition of Group That Authored the Guideline

Committee Members: Dr Michael Smith (*Chair*), Clinical Director, Australian Commission on Safety and Quality in Health Care, New South Wales; Associate Professor Andrew Chanen, Orygen Youth Health Research Centre, Centre for Youth Mental Health, The University of Melbourne, Acting Director of Clinical Services, Orygen Youth Health, Victoria; Mr Fred Ford, Carer Representative, Mental Health Council of Australia, New South Wales; Professor Brin Grenyer, Scientific Director, Neuroscience and Mental Health, Illawarra Health and Medical Research Institute, Professor of Psychology, University of Wollongong, New South Wales; Professor Jane Gunn, Chair, Primary Care Research, University of Melbourne, Head, Department of General Practice, General Practice and Primary Health Care Academic Centre, Melbourne Medical School, University of Melbourne, Victoria; Professor Mike Hazelton, Head, School of Nursing and Midwifery, The University of Newcastle, Fellow, Australian College of Mental Health Nurses, New South Wales; Dr Anthony Korner, Senior Lecturer, University of Sydney, Acting Director, Westmead Psychotherapy Program, Senior Staff Specialist, Sydney West Area Health Network, New South Wales; Ms Janne McMahon, Chair and Executive Officer, Private Mental Health Consumer Carer Network (Australia), South Australia; Professor Louise Newman, AM, Director, Monash University Centre for Developmental Psychiatry and Psychology; Professor of Developmental Psychiatry, Monash University, Victoria; Dr Sathya Rao, Clinical Director and Consultant Psychiatrist, Spectrum, The Personality Disorder Service for Victoria, Victoria; Ms Teresa Stevenson, Specialist Clinical Psychologist, Discipline Coordinator of Psychology and Team Leader, Early Episode Psychosis Program, Peel and Rockingham Kwinana Mental Health Services, Western Australia

Financial Disclosures/Conflicts of Interest

Managing Declarations of Interest of the BPD Guideline Committee

Conflicts of interest can be categorised as potential, perceived or actual, and relate to members' interests as well as the interests of their family related to the guideline topic. Interests may be direct or indirect, pecuniary or non-pecuniary.

Members of the Committee were required to declare their relevant interests in writing prior to consideration for appointment to the committee. The purpose of declaring conflicts of interest was to avoid or manage real or perceived conflicts of interest between the private interests of committee members (including pecuniary interest or the possibility of other advantage) and their duties as part of the committee.

Committee members were required to update their information as soon as they became aware of any changes in their circumstances. There was also a standing agenda item at each meeting where conflicts of interest were solicited and recorded as part of the meeting minutes.

At the Committee meeting in May 2011, one of the committee members, A/Prof Andrew Chanen, noted that his research featured in the evidence available to support the committee's deliberations in formulating recommendations in response to the evidence table for clinical questions 1 and 2. A/Prof Chanen chose to leave the room, but the committee unanimously agreed that his skills and expertise relating to the issue at hand would make a valuable contribution to the committee's deliberations. A/Prof Chanen was invited by the Chair to re-join the meeting and participate in the discussion. A/Prof Chanen chose to abstain from participating in the discussion to formulate recommendations for clinical questions 1 and 2.

At the Borderline Personality Disorder Committee meeting in December 2011, in order to manage conflict of interest, A/Prof Chanen did not participate in discussions about section 4.3 of the draft guideline, which references one of his papers.

All declarations of interest were added to a register. This register of declarations of interest was viewed by the Chair of the Committee, and National Health and Medical Research Council staff, and made available to the committee. Disclosure of the register to the committee was important as it allowed committee members to take all potential conflicts of interest into consideration during discussions, decision-making and formulation of recommendations. There were no further occasions where this conflict of interest process was applied.

Committee members' declarations of interest are listed in Table 1.3 in the original guideline document.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Electronic copies: Available from the [National Health and Medical Research Council \(NHMRC\) Web site](#) .

Availability of Companion Documents

The following are available:

- Clinical practice guideline for the management of borderline personality disorder. Appendices. Melbourne (Australia): National Health and Medical Research Council; 2012. 188 p. Electronic copies: Available from the [National Health and Medical Research Council \(NHMRC\) Web site](#) .
- Clinical practice guideline for the management of borderline personality disorder. Appendix H: evidence tables. Melbourne (Australia): National Health and Medical Research Council; 2012. 469 p. Electronic copies: Available from the [NHMRC Web site](#) .
- Caring for people with borderline personality disorder: a reference guide for health professionals. Melbourne (Australia): National Health and Medical Research Council; 2013. 42 p. Electronic copies: Available from the [NHMRC Web site](#) .

In addition, templates for borderline personality disorder (BPD) management are provided in section 10 of the [original guideline document](#) .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on October 27, 2014. The information was verified by the guideline developer on December 1, 2014.

Copyright Statement

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